THE OHIO STATE UNIVERSITY

Department of
Emergency Medicine

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7/23/2020

Written report and opinions regarding the care of JAMES PATRICK GEARY

Background

Feb 25th Podiatry Clinic
Mr. Geary is a 61 year old male who had a history of foot wounds (bilateral) for which he was being treated at the podiatry clinic. He is a type II diabetic and his foot wounds are considered to be related to his diabetes.

March 13th ED Visit: Dr. Melissa Butler
His first visit to the ED was on March 13th, with complaints of increasing pain in his right leg and foot for 4 days after returning from a vacation in which he did a lot of walking. His x-rays showed mild soft tissue swelling but no significant acute findings. Lab work was normal. He was treated with a Medrol Dose Pack and discharged.

March 18th ED Visit: Dr. Melissa Butler
The patient presented again with severe worsening pain in his right leg and foot which was described as 10/10. He manifested tachycardia with a rate of 118. A CT of the foot and ankle showed a possible fluid collection around the peroneus brevis and longus tendons and this was thought to be a possible tenosynovitis per radiology. He was seen by the same physician who initially treated him 5 days earlier.

March 22, 2019, Prime Care Clinic: Dr. George Rizk
The patient presented to his primary care doctor with tenderness to palpation over lateral malleolus with no known injury and in the context of worsening pain in a patient with a diabetic foot wound. He was discharged with no additional testing.

March 25th ED visit: Fred Gabriele, CNP
The patient was seen again in the ED for Right ankle pain since 3/9/19. He had new right wrist pain for 2 days and new left knee since previous evening. The pain was described as 10/10. Prednisone was given and he was discharged with no additional testing to attempt to discover the cause of ongoing pain and new joint involvement.

March 30th ED visit
He was brought in by ambulance for worsening pain. He complained of severe generalized pain including swelling and redness of the right wrist and ankle, and pain in back, and lower

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abdomen. He also had shortness of breath with inspiratory effort triggering pain in abdomen along with loss of appetite. At this time he was appropriately treated and admitted for surgical consultation.

March 31st Surgical service
He was seen and operated on by the surgical service. The found the following:

1. Extensive soft tissue infection including suppurative tenosynovitis around the ankle and possible septic arthritis at the talonavicular joint/mid foot joints
2. Extension of soft tissue infection with purulence into the posterior compartment along the tendons of right posterior tibialis and flexor tendons.
3. Extensive soft tissue infection on the medial aspect of the right ankle with extension into the plantar space.
4. Soft tissue edema without any clear abscess in the right distal forearm on the medial side.
5. There was NO evidence of fascial "sliding sign" anywhere in the soft tissues and most of the infected areas had a lot of purulent fluid.

"It is definitely extensive soft tissue infection due to most likely Staphylococcus aureus with some gas bubbles."

April 5th Miami Valley Hospital
He underwent a right sided below-knee amputation (BKA).

Opinions

1. On or about March, 18th during the ED visit with Dr. Melissa Butler, there was sufficient suspicion to pursue additional imaging (MRI) and specialty consultation (podiatry/orthopedics) given the finding of a fluid collection around the peroneus brevis tendon which suggested a tenosynovitis. Further, Dr. Butler was already familiar with this patient for having seen him on March 13th. She was aware that her initial treatment with steroids (Medrol) was not effective and his symptoms did in fact become worse. Given his history of a diabetes with a foot wound and a CT suggesting a fluid collection, ruling out an infectious cause for this tenosynovitis was mandated.

Basis

- He presented with worsening pain despite attempts at increased pain control.
- He had a history of known diabetic ulcers with poorly controlled diabetes
- He presented with abnormal vital signs
  - Tachycardia
- He had a CT showing a fluid collection suggesting tenosynovitis (not a benign diagnosis).

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- The ED physician (Dr. Butler) had the benefit of having seen him previously and was aware her initial treatment was ineffective.

2. On the March 22nd visit to his primary care doctor, George Rizk, MD, the patient should have been immediately referred for further imaging (MRI) and specialty consultation (podiatry/orthopedics) given the previous findings and persistent, worsening condition. He was instead discharged with no additional testing

Basis

- The patient had known diabetes with a diabetic foot ulcer.
- He had been seen on 2 previous occasions in the ED with no improvement and worsening of his symptoms.
- He had no history of any injury to explain his symptoms.

3. On the March 25th ED visit, the patient clearly manifested a constellation of symptoms to warrant significant consideration for multiple septic joints. The CNP, Fred Gabriele who saw Mr. Geary in the ED did not pursue any further evaluation, despite worsening symptoms and new joint involvement. He was discharged with more immunosuppressive steroids.

Basis

- He presented with worsening pain despite attempts at increased pain control.
- He presented with new right knee pain and new right wrist pain suggesting progression to infection involving multiple joints.
- He presented with tachycardia.
- He was unable to bear weight.
- He is a diabetic on immunosuppressive steroids.

4. Missing the diagnosis of septic arthritis/infectious tenosynovitis and an abscess of the ankle despite multiple visits, in context of worsening and progressive symptoms led directly to the need for amputation of the leg.

5. The care provided to Mr. Geary falls below the standard of care for the providers, Dr. Melissa Butler (ED), Mr. Fred Gabriele, CNP (ED) and Dr. George Rizk (Primary Care), ultimately leading to the need for a below-knee amputation.

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6. Had Mr. Geary received proper care in a timely fashion by Dr. Melissa Butler (ED), Mr. Fred Gabriele, CNP (ED) and Dr. George Rizk (Primary Care), his infection would not have led to the need for a BKA.

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